Commission on the Future of Health Care in Canada

Commission sur l'avenir des soins de santé au Canada

ISSUE/SURVEY PAPER

Globalization and Canada's healthcare system

JULY 2002

This paper is one of a series of nine public issue/survey papers designed to help Canadians make informed decisions about the future of Canada's healthcare system. Each of these research-based papers explores three potential courses of action to address key healthcare challenges. Canada may choose to pursue some, none, or all of these courses of action; in addition, many other options are available but not described here. These research highlights were prepared for the Commission on the Future of Health Care in Canada, by the Canadian Health Services Research Foundation.

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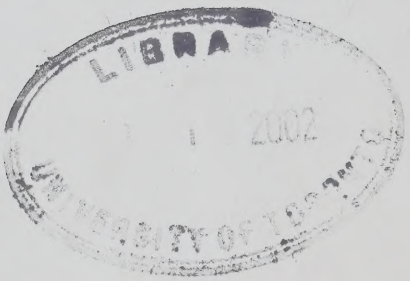
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Thank you for your interest in shaping the future of Canada's healthcare system.

This issue/survey paper on the globalization and Canada's healthcare system is one of a series of nine such documents the Commission on the Future of Health Care in Canada has developed in partnership with the Canadian Health Services Research Foundation. They were designed to enable Canadians to be better informed about some of the key challenges confronting their health care system and to express their preferences on proposed solutions. We have worked hard to summarize relevant, factual information and to make it as balanced and accessible as possible.

Each of our nine documents follows an identical format. We begin by briefly summarizing a particular health issue. Next, we identify three possible courses of action to address the issue and their respective pros and cons. Last, we ask you to complete a brief survey relating to the courses of action.

To make it easier to provide us with your responses, the survey questions are included on the final pages of this document. Please detach and forward these pages to us by fax at: (613) 992-3782, or by mail at:

Commission on the Future of Health Care in Canada
81 Metcalfe, Suite 800
Ottawa, Ontario
Canada K1P 6K7

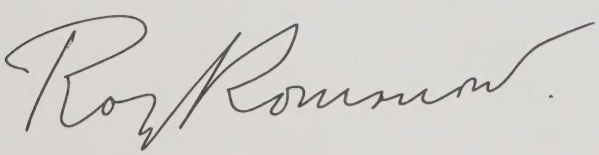
You can also complete the survey on-line through our interactive website at: www.healthcarecommission.ca.

There are no "right" or "wrong" answers, and the results are intended to be informational only. They are designed to illustrate how each person's response fits within the context of others who have responded, not to have scientific validity in and of themselves. The survey results are only one of many ways the Commission is studying and analyzing this issue. To order other titles in this series, please write to us at the address above, or call 1-800-793-6161. Other titles include:

- Homecare in Canada
- Pharmacare in Canada
- Access to healthcare in Canada
- Sustainability of Canada's healthcare system
- Consumer choice in Canada's healthcare system
- The Canada Health Act
- Human resources in Canada's healthcare system
- Medically necessary care: what is it, and who decides?

We are grateful for your contribution to shaping Canada's healthcare system and hope that this document will be as informative to you, as we know your survey responses will be valuable to us.

Sincerely,



Roy Romanow

Globalization and Canada's healthcare system

The world Canadians live in is shrinking. We travel in planes and cyberspace. We connect by phone and e-mail, conduct worldwide business over the internet, and watch distant realities unfold live on TV.

This growing interdependence of people and societies, made possible by technological innovation, has led to vast economic changes including the liberalization of international trade of all kinds. "Globalization," as it's called, affects our health and our healthcare system as well, although the impact may not yet be as apparent. But is it a force for good or ill?

Certainly nobody welcomes the arrival on our shores of foreign diseases such as the West Nile virus, mad cow disease or new strains of tuberculosis. Yet many Canadians benefit from an increasingly interconnected world through using new medical treatments developed abroad, by selling Canadian health technology on the global market, and by participating in international disease-prevention projects.

In many ways, our ever-more permeable borders spell both opportunity and challenge. For instance, some health professionals pack their bags to seek their fortunes elsewhere, even as doctors and nurses from abroad clamour for a chance to work here.

Still, our healthcare system as a whole remains remarkably untouched by the forces of globalization. There's very little "healthcare tourism", for example; most Canadians get their care at home and not many come from abroad to be treated in this country. Foreign ownership of medical enterprises is also, so far, relatively rare.

This situation could change, however, due to Canada's signing of the 1994 North American Free Trade Agreement (NAFTA) and our membership in the 144-nation World Trade Organization, founded in 1995, through which we participate in the General Agreement on Trade in Services, or GATS, which took effect in 1995.

Free trade encourages the flow of goods, money and services across international borders. Between them NAFTA and GATS have greatly expanded the influence of private enterprise on public policy. While neither agreement specifically addresses Canada's publicly funded healthcare system, both could influence it down the road. Experts, however, disagree on the nature and extent of that impact.

This paper focuses on three of the many potential courses of action for Canada in this era of global economic integration:

I. The federal government could continue to protect our public medicare system in all international trade negotiations.

II. Provincial governments could agree to pay for healthcare services that patients choose to obtain abroad.

III. The federal government could promote a freer flow of healthcare professionals under international trade agreements.

I Protecting medicare in international trade agreements

The federal government is an enthusiastic proponent of liberalized international trade in goods and services, arguing it will bring us greater prosperity and opportunity. But because the impact of freer trade in health services is uncertain, the government "protected" healthcare, ensuring that it's not ruled by the conditions of either the North American Free Trade Agreement or the General Agreement on Trade in Services. Healthcare, Canada argued, is a public good administered by governments.

This means Canada can continue to set domestic healthcare policies without fear of violating international trade rules. Governments use an assortment of laws and funding mechanisms to restrict competition in what's considered the key area of medicare — the delivery of medically necessary services by doctors and hospitals. If healthcare were not exempted from the trade agreements, limits on what private providers are allowed to do could be challenged as a contravention of international trade commitments.

For now, Canada's healthcare system remains generally untouched by trade liberalization. While it is true that private financing and delivery both play significant roles, our medical system can still be described as owned and operated by Canadians, and financed by the government purse.

How long this will remain so is unclear. Private investors are permitted certain business opportunities in the healthcare field; opponents of free trade fear that could trigger demands from businesses for more opportunities to invest in Canadian healthcare. For instance, under Alberta's Bill 11, private for-profit companies are being paid public funds to deliver certain hospital services, in competition with non-profit public hospitals — could this lead to a trade challenge from investors who want to do the same in other provinces? Recent GATS negotiations on financial services officially opened our commercial health-insurance market (such as private insurance for drugs) to foreign investment, and some observers contend this could eventually have an impact on our governments' ability to expand or alter our publicly funded healthcare system.

In this evolving trade environment, the protections afforded by the trade treaty exemptions are not entirely clear. Much of the language of both agreements is quite broad: Health services delivered under the authority of governments are mentioned only among the list of items excluded from the full impact of trade liberalization rules. And so far, there has been little testing of the strength of those exemptions before international trade dispute-resolution bodies.

Course of Action: The federal government should protect our public medicare system in all international trade negotiations.

If the federal government wanted to enhance protection of medicare from the effects of free trade, it could attempt to clarify the wording of its commitments and exemptions under NAFTA and GATS to ensure that medically necessary services delivered by doctors and in hospitals remain in the public domain and are not subject to freer international trade rules or sanctions.

Then, as NAFTA is extended to include 31 Latin American and Caribbean nations by 2005, and World Trade Organization negotiations continue, Canada would need to make clear to all its trading partners that our public-funding system for medically necessary healthcare services is not on the bargaining table.

ARGUMENTS FOR

Our healthcare system is an essential public good that embodies core Canadian values. Many Canadians accept that the single-payer, publicly administered structure of medicare is essential for maintaining universal equity of access to health services and national control over our healthcare policies.

Canada's medicare system is the best way to curb expenditures without compromising our excellent health status. Medicare is what's known as a single-payer health insurance system, where, through government, everyone shares the costs of everyone else's illnesses. Everybody, including the poorest, are protected from the costs of illnesses that could otherwise ruin them and no one pays disproportionately for healthcare, whatever their personal needs or circumstances. Single-payer systems have greater power to negotiate payments to physicians and lower prices for drugs. They also save money because of their substantially lower overhead costs and efficient, centralized administration.

International trade treaties make it harder for governments to get into new service areas. Once liberalized, a trade sector is difficult to close off again to foreign investors. That means, for example, that because homecare and pharmacare programs already have extensive private-sector involvement, Canada could find its options for developing national programs limited under the terms of trade agreements. International investors displaced by new publicly funded services could challenge such new programs and perhaps claim compensation.

Greater trade liberalization could allow foreign investors to make a profit from our public healthcare funds. Under NAFTA, any U.S. corporation can argue it is entitled to the same opportunities afforded Canadian private-sector companies. If that argument were used to allow U.S. firms to offer healthcare currently provided by government, medicare funds collected from Canadian taxpayers might end up boosting the bottom line of healthcare companies based beyond our borders.

Canadians may favour the delivery of healthcare services by providers with a stake in protecting Canadian interests. Canadians may be leery about private health information being shipped to foreign nations, where leaks would be hard to detect and offenders might escape the reach of Canadian law. Similarly, corporate health-service managers may put more emphasis on consumer safety, worker health and other important standards if they themselves live in the community and would suffer equally from poor decisions.

ARGUMENTS AGAINST

Liberalized trade in healthcare services could mean more choices for consumers. Foreign providers might introduce new healthcare services to Canada if they thought they could make money. As the menu of offerings broadened, competitive pressures could lead both domestic and foreign providers to improve and modernize their services.

We have a very impressive healthcare system full of innovation and ideas that we could offer abroad. We are already building specialty hospitals in India; perhaps free trade in healthcare would encourage other nations to bring their innovations to Canada and Canada could in turn develop foreign markets for our expertise.

Increased trade and foreign investment in all sectors, including the healthcare industry, can boost economic growth, create jobs and lead Canada's transformation into a knowledge-based economy. We could reinvest this enhanced wealth in improved healthcare and social services for all Canadians.

SURVEY QUESTIONS

Please refer to page 11 for the survey questions for this section.

II. Paying for treatments abroad

Canadians get healthcare in the United States or other countries for a variety of reasons. For the most part, it's because they fall ill while travelling and wind up in foreign clinics. Others deliberately seek out care that is not available here, or is considered better elsewhere. In all, however, the numbers are quite small: fewer than one in a thousand Canadians ever sees the inside of a foreign medical facility. And when you subtract the emergency cases, just a few hundred Canadians a year pack their bags in an active quest for cross-border care.

More Canadians might go abroad for services if money were not a consideration. Canadians are covered by government insurance for most physician and hospital care only as long as they remain in the country. Private traveller's insurance covers accidents and emergencies, but not elective care.

Still, there are exceptions. Most provinces have sent patients to nearby states for certain types of care when there's been a shortage of doctors, beds or technicians at home. It is common, for example, for Canadians to be sent south for cancer radiation treatments when waiting times here grow too long. Provinces will also authorize payments for individuals referred to specialized foreign centres for experimental or other treatments not available locally, provided the request is approved in advance.

Recently, a Senate committee studying healthcare reform recommended the government cover the costs of out-of-country treatment obtained by patients waiting unacceptably long periods, which would be defined by panels of experts for every major procedure.

Some patients are already taking matters into their own hands. In one recent Ontario case, an appeal board ordered the provincial health plan to reimburse a patient who flew to England for cancer surgery because he feared he would wait too long at home.

The European Court of Justice has also recently issued similar decisions. Patients forced to wait too long for care now have the right to obtain fully funded hospital treatment in the European Union nation of their choice, without the need for prior authorization from their own country.

Course of action: If a patient travels abroad to use a healthcare service that is either not available or is not available on a timely basis in Canada, governments should pay for the treatment.

Free trade is changing the face of Europe, where the member countries of the European Union have all but done away with passport controls amongst themselves and many (but not all) of the nations now share a common currency, the Euro. It's perhaps inevitable that people there are increasingly travelling to other countries for their healthcare.

Of course, such travel is easier in Europe, where distances between countries are smaller, but Canada, too, could choose to develop a system where people go where the care is, rather than waiting for it to be available at home. We could have standing contracts with foreign (most likely U.S.) providers, on the understanding that anyone facing a wait longer than experts have judged acceptable would simply go away for care. It wouldn't likely be a free-for-all; rates, travel allowances and approved extras would probably have to be carefully negotiated with both the provider and the patient, and would be limited to standard medical treatments. The treatments would be the same as those offered in Canada and foreign providers assessed and chosen by Canadian experts for the quality of care they offer.

The United Kingdom is already grappling with this idea by establishing a formal mechanism, complete with competitive bidding processes and defined quality standards, to organize out-of-country care for its citizens. Though details are still being worked out, the new scheme, which is to be in place by 2005, would give U.K. citizens the opportunity to get diagnostic care or treatments outside of Britain if they needed to and the costs would be reimbursed by the public health insurance plan as though the service had been delivered at home.

Arguments for

Healthcare consumers want more opportunity to get the healthcare they need, even if they have to travel abroad to get it. The government is responsible for ensuring reasonable standards of patient service; if the obligation cannot be met at home, it must be met elsewhere. Canadians opting for care from foreign providers approved by Canadian authorities would also have confidence that the service meets our domestic standards for quality.

Our healthcare system could save money. Even factoring in the cost of travel, Canadians could obtain many advanced services abroad at lower cost than at home. For example, a liver transplant in India costs one-tenth the going rate in the United States. Moreover, because Americans don't like to wait for healthcare, they tend to have a lot of extra space in their system; Canadians could be treated in extra U.S. beds and save the cost of building our own facilities.

Forced by the courts to pay for out-of-country medical care, provinces may be more inclined to improve access to domestic healthcare services. Faced with the prospect of paying the cost of out-of-country travel, provinces may look more seriously at improving the management of waiting lists and clearing up treatment backlogs.

Arguments against

This could skew Canada's long-standing approach to delivering medical care on the basis of medical need rather than want. It might be that promising treatment more quickly, even if it means going abroad, will undermine our efforts to ensure the people who most need treatment get it first. Some people may insist on an immediate operation, even if their condition is not critical; others may wait unduly long because age, family obligations or some other consideration makes them disinclined to travel.

Medicare is already paying for some services abroad, only it's being done in a controlled and fiscally responsible way. Now, it's governments, in consultation with health professionals and expert advisers, that decide how the taxpayer-funded public system will pay for legitimate medical treatments. Pressure on the system is to some extent a management tool; there are, for example, treatments that won't do much good or that may not be necessary immediately.

This is just a short-term solution to a long-term problem. Governments should be looking to other means, including tax hikes or more private Canadian investment, to increase our domestic healthcare capacity and keep health spending in Canada.

Survey questions

Please refer to page 11 for the survey questions for this section.

III

Promoting the free flow of healthcare professionals across international borders

From time to time, we read news reports of Canadian doctors and nurses fleeing in droves to the land of opportunity south of the border. The truth is, we can't be sure how big the problem is, or whether we even have a problem.

We have no good statistics on the number of nurses leaving or entering Canada. As for doctors, 420 left in 2000 (we're not sure where they went, although most probably chose the United States) and 256 arrived, for a net loss of 164. That's less than a third of one percent of Canada's active physician workforce — hardly the hallmark of a mass exodus.

Even so, there are frequent debates on whether Canada is facing — or already suffering — a shortage of healthcare professionals. But whatever the disagreements, there is widespread consensus that certain areas of the country — especially rural and remote regions — and some medical specialties really do have too few practitioners.

Provinces have for some time been experimenting with a variety of incentives to encourage health professionals to work in under-serviced areas. One frequently proposed solution is to bring in more foreign-trained physicians and to arrange their registration and continuing education in a way that encourages them to stay where they are most needed.

Under the North American Free Trade Agreement and the General Agreement on Trade in Services, Canada is not obliged to permit the free flow of health professionals across international borders. NAFTA says registered nurses and physicians involved in teaching or research may obtain temporary admission but the idea is that they pursue enterprise opportunities, such as investing or buying a business. Only when there's a national shortage of labour can foreigners be brought in to fill a full-time practice position in their field. Similarly, GATS promotes temporary labour mobility, but Canada's healthcare sector, including its providers, is not directly affected.

Thus, foreign providers can arrive at our shores as they always have: as refugees from political turmoil, as part of a family reunification process, as regular immigrants or as specialized experts recruited by a Canadian healthcare facility.

To work and be paid here, foreign health professionals entering by the traditional immigration or refugee routes must meet provincial registration requirements. This is easy for Americans, since our certification rules are largely in harmony. It is more complicated for professionals from other countries, where training and practice standards may be different.

Course of action: The federal government should negotiate the free flow of healthcare professionals in international trade agreements.

Canada should follow the lead of the European Union and permit freer mobility of health personnel. To do so, it could put the mobility of health professionals on the table in the current round of GATS negotiations or during the upcoming expansion of NAFTA into the Free Trade Area of the Americas (FTAA).

With looser rules on migration, however, Canada's challenge would be to preserve our high professional standards. Since Canada could not discriminate against foreign healthcare workers no matter where they obtained their credentials, provincial licensing, certification and professional bodies would take on an even greater role in ensuring an acceptable calibre of immigrant practitioner.

The government could also support the training and continuing education of international medical graduates within Canada, to be certain they met our standards.

Arguments For

This is an effective way to compensate for shortages in the healthcare workforce. If we relied only on inter-provincial migration to redress occasional human resource shortages, we would be depleting professional ranks in one province in order to increase them in another. Opening our borders to foreign health professionals avoids that problem.

We could save money. Given the high cost of educating healthcare providers, it makes economic sense to hire workers trained elsewhere.

Healthcare providers have access to new opportunities. With the rapid pace of developments in medicine, it should be easier for providers to go abroad to expand their professional experience, gain more income, find better professional resources or seek opportunities for travel and continuing education. While the permanent departure of healthcare workers would hurt Canada, those who returned would enrich the practice of medicine.

Arguments Against

We could end up with more health professionals than we need or can afford. Under the Charter of Rights and Freedoms, Canada cannot dictate to landed immigrants where they can work. If foreign doctors preferred to settle in urban areas that might already be well serviced, we could end up with too many doctors where we don't need them. As long as they have a provincial billing number, they can see patients and charge the public medicare plan.

We could end up with a poorer quality of workers from less developed parts of the world. Individual foreign-trained doctors can do as well as Canadian medical school graduates on qualifying exams. As a group, however, they do substantially worse. This could be due to language and cultural barriers, the length of time that has passed since they graduated from medical training, or a lower quality of training. In fact, many medical schools listed in World Health Organization directories do not feature rigorous accreditation procedures or program standards. Relaxing international mobility rules could require us to harmonize our training and licensing standards, which means they might wind up being lower.

Making it easier for health professionals from developing countries to come to Canada will deplete their numbers where their skills are urgently needed. Commonwealth countries have already recognized the potential danger of such "poaching" of healthcare workers, and have urged developed countries to devise and adhere to codes of conduct. More open borders could, however, make controls difficult. Promoting the migration of health personnel from poorer countries also contravenes Canada's own international aid and development policies.

Survey Questions

Please refer to page 11 for the survey questions for this section.

Acknowledgements

This document was produced by the Canadian Health Services Research Foundation, in partnership with the Commission on the Future of Health Care in Canada. The topics and courses of action reflect key issues raised frequently in the Commission's consultations to date, for which the Foundation was able to find relevant research evidence to help inform the debate.

This document has been reviewed by the following experts for accuracy and fairness, but final responsibility lies with the Canadian Health Services Research Foundation:

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World Bank Institute

A complete bibliography of the research used to prepare these documents can be found at www.healthcarecommission.ca.

SURVEY INSTRUCTIONS

Please detach the following pages and forward to us by fax at:
(613) 992-3782

Or by mail at:
Commission on the Future of Health Care in Canada
81 Metcalfe, Suite 800
Ottawa, Ontario
Canada K1P 6K7

For information:
Call toll free at 1-800-793-6161
www.healthcarecommission.ca

Thank you

Survey Questions

Please indicate your opinion on each of the following questions by checking the appropriate response.

Protecting Medicare in International Trade Agreements

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. Healthcare in Canada would improve if the federal government protected our single-payer medicare system in all international trade negotiations.	❑	❑	❑	❑	❑
2. Foreign for-profit healthcare companies would bring useful competition and choice to our healthcare system.	❑	❑	❑	❑	❑
3. It's important that in international trade negotiations, Canada protect its ability to develop new government-funded national healthcare programs, like homecare or pharmacare.	❑	❑	❑	❑	❑
4. It doesn't make a difference to me whether the hospitals and healthcare organizations which provide my care are Canadian-owned or not.	❑	❑	❑	❑	❑

Paying for Treatments Abroad

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. Healthcare in Canada would improve if governments paid the costs of patients choosing to go abroad for treatment not adequately available in Canada.	❑	❑	❑	❑	❑
2. Governments should increase healthcare spending to cover the costs of patients choosing to go abroad for treatment not adequately available in Canada.	❑	❑	❑	❑	❑
3. If governments were to pay for patients to go abroad for treatment, it should be limited to cases where the wait for care in Canada would be longer than a group of experts defines as safe.	❑	❑	❑	❑	❑
4. If governments were to pay for patients to go abroad for treatment, patients should not have to get prior approval as long as they went to foreign facilities that had agreements in place with Canadian governments.	❑	❑	❑	❑	❑

PROMOTING FLOW OF HEALTHCARE PROFESSIONALS

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. Healthcare in Canada would improve if the federal government negotiated the free flow of healthcare professionals in international trade agreements.	❑	❑	❑	❑	❑
2. Governments should increase healthcare spending to provide healthcare professionals immigrating to Canada with appropriate training and certification to practice in Canada.	❑	❑	❑	❑	❑

3. Which comes closest to your own opinion?

We should encourage more doctors to immigrate to Canada, even if we draw them away from countries that really need them.

OR

We should focus on creating and keeping more healthcare professionals in Canada rather than seeking them elsewhere.

Strongly Agree Encourage Immigration	Agree Encourage Immigration	Neutral	Disagree Focus on Canada	Strongly Disagree Focus on Canada
❑	❑	❑	❑	❑

ANALYSIS INFORMATION

Please complete the following information for analysis purposes. Thank you.

Gender: ❑ Male ❑ Female

Age: ❑ under 18 ❑ 19-29 ❑ 30-49 ❑ 50-65 ❑ over 65

Province or Territory in which you reside: _____

Continued ...

Your annual household income from all sources before taxes is: (Optional)

Choose one:

❑ Less than $20000

❑ $20000 to $39999

❑ $40000 to $59000

❑ $60000 to $79000

❑ $80000 to $99000

❑ More than $100K

The highest level of schooling you have completed is: (Optional)

Choose one:

❑ Elementary School or less

❑ Secondary School

❑ Community College/CEGEP/Trade School

❑ Prof./Trade Certification

❑ Bachelor Degree

❑ Graduate Degree

Are you a healthcare professional? (Optional)

❑ Yes ❑ No

Approximately how many times in the last year have you personally used the healthcare system? (eg. seen a doctor or specialist, spent time in the hospital, received care in a hospital emergency room, etc.) (Optional)

Choose one:

❑ 0-3

❑ 4-6

❑ 7-9

❑ More than 10

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